INMATE INJURY REPORTING AND LIABILITY 6454

(No.15 February 2011)

Responsibility

All

Work related injuries or illnesses sustained by inmates are reported according to the circumstances surrounding the occurrence. Additionally, establishing the appropriate Department responsible for costs involved with settlement of Workers' Compensation claims also depends on the circumstances surrounding the occurrence (see Exhibit 6454, Injury Liability Matrix).

As a general rule, payment of any related costs is the responsibility of CDCR. The two exceptions are when the inmate injury occurs during fire suppression on a CAL FIRE DPA incident, or when the injury occurs during fire training and the inmate is assigned to a conservation camp (not FTP) (see Exhibit 6454, Injury Liability Matrix).

If an inmate is injured on a CAL FIRE work project, a federal fire or on any emergency incident other than a CAL FIRE DPA fire, and if the inmate is not engaged in fire training while assigned to a conservation camp, CDCR is responsible for costs, including Workers' Compensation. If the injury is reportable to State Fund the following forms are to be completed by the supervisor: Employee's Claim for Workers' Compensation Benefits, DWC-1/SCIF-3301 and Department of Corrections Report of Inmate Occupational Injury or Illness, SCIF-3580.

If the inmate is injured on a CAL FIRE DPA fire, or during fire training while the inmate is assigned to a conservation camp, CAL FIRE is responsible for costs including Workers' Compensation. If the injury is reportable to State Fund then an Employer's Report of Occupational Injury or Illness (CAL FIRE-3067), and an Employee's Claim for Workers' Compensation Benefits (DWC-1/SCIF-3301) are required to be completed by the supervisor of the injured ward.

COMPLETION OF INMATE INJURY REPORTS 6454.1

(No.15 February 2011)

Responsibility

All

Any time an inmate is injured while under the direct supervision of CAL FIRE, the supervisor of the injured inmate shall create a report of the injury using the Injury Prevention and Assessment System (IAPS) Electronic Worksheet. (See Safety Handbook Section 1712, and Workers' Compensation Handbook, Sections 1920.1 (State Fund Reportable) and Section 1920.2 (CAL FIRE Record Only). This report is required by CAL FIRE regardless of which Department is considered to be the employer for workers' compensation purposes.

When an injury or illness to an inmate is reported using the IAPS Electronic Worksheet the following forms will be generated at the camp level after the Electronic Worksheet has been forwarded to the Unit RTWC for review:

SCIF-3580 - If State Fund liability is with CDCR and it is a Reportable Claim.

Inmate Injury Notification Form – If the State Fund liability is with CDCR and it is not reportable to State Fund. The form will also be printed whenever the State Fund liability is with CAL FIRE.

If State Fund liability is with CAL FIRE the IAPS Case Management System will generate a CAL FIRE-3067 claim form for the home Unit RTW coordinator. For guidelines, responsibilities, completion, submission, and retention information, see the 1700 Safety Procedures Handbook Section 1712, and the 1900 Workers' Compensation Procedures Handbook sections 1921, 1922, 1923 and 1924.

EMPLOYEE'S CLAIM FORM (SCIF-3301) 6454.2

(No.15 February 2011)

Responsibility

Camp Commander
Division Chief

The Employee's Claim for Workers' Compensation Benefits (SCIF-3301) must be given to the injured inmate within 24 hours of the injury for inmates who sustain reportable work-related injuries or illnesses. All pertinent sections of the form, per instructions contained in Section 1922.1 of the CAL FIRE Workers' Compensation Procedures Handbook will be completed.

The form is completed according to the circumstances under which the accident occurred. For inmate injuries occurring during CAL FIRE DPA fire suppression or during fire training exercises (except during training conducted by an institution-based Forestry Training Program), CAL FIRE is considered the employer. (See SCIF 3301 sample.)

Additional assistance for completion of the form can be found in the "Supervisors WC Claim Kit" located on the CAL FIRE Intranet at http://cdfweb/EmployeeInfo/humanResources/WCEmployeeClaimKit.htm

An electronic fillable form is available on the CAL FIRE Intranet at http://cdfweb/Library/ElectronicForms/msword/scif3301.pdf

For all other cases, CDC is considered the employer.

The examples below indicate those sections which require specific information according to the above circumstances. Many of the blanks are self explanatory and not illustrated in these samples.

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it **"Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401**. An explanation of workers' compensation benefits is included as the cover sheet of this form.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. En la hoja cubierta de esta forma esta la explicatión de los beneficios de compensación al trabjador.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

The following section illustrates entries to be made in selected sections of the SCIF-3301 "Employee" block where the injury was **NOT** a result of CAL FIRE DPA fire suppression or fire training activities. If the injury resulted from other emergency activity (like flood control or a Federal fire), indicate the incident type jurisdiction, incident name, and location in number "5".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre. (Enter inmate's full name and inmate number)*_____Today's Date. *Fecha de Hoy.*___(Date completed)_____
2. Home Address. *Dirección Residencial.* (Enter CDC's camp address where inmate is assigned)_____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.*_____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   (Enter address or location where injury occurred)_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.*__(Use physician's description if available_____
   ____ State body part and injury. List primary injury(s) first, then secondary injury(s).)_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.*___(Form must be signed by the injured or a representative)_____

The following entries in the “Employee” block are made when the injury occurred during CAL FIRE DPA fire suppression or during fire training activities (except training administered by an institution-based Forestry Training Program).

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* *(Enter inmate's full name and inmate number)*_____Today's Date. *Fecha de Hoy.*___(Date completed)_____
2. Home Address. *Dirección Residencial.* (Enter CDF's camp address where inmate is assigned)_____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.*_____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
   (Enter "fire site" plus the incident name and number and location of the fire)_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.*__(Use physician's description if available_____
   ____ State body part and injury. List primary injury(s) first, then secondary injury(s).)_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. Signature of employee. *Firma del empleado.*___(Form must be signed by the injured or a representative)_____

Entries in the “Employer” block of the SCIF-3301 should conform to the following notations when the injury did **NOT** occur during CAL FIRE DPA fire suppression or during fire training activities. These entries are appropriate for injuries occurring during fire training administered by an institution-based Forestry Training Program.

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _(Enter the name of the institution to which the inmate is assigned)_____
10. Address. *Dirección.* _Enter the address of the institution to which the inmate is assigned_____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    State Compensation Insurance Fund (Enter address of SCIF office assigned to the institution)_____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _N/A_____
16. Signature of employer representative. *Firma del representante del empleador.* (Form must be signed. It does not admit liability)_____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

SCIF 3301 (REV. 7-04) - DWC Form 1 (REV. 7-04)

STATE COMPENSATION INSURANCE FUND

Entries in the “Employer” block of the SCIF-3301 should conform to the following notations when the injury did occur during CAL FIRE DPA fire suppression or during fire training activities training administered by an institution-based Forestry Training Program.

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

9. Name of employer. *Nombre del empleador.* _(Enter the name of the institution to which the inmate is assigned)_____
10. Address. *Dirección.* _Enter the address of the Unit to which the inmate is assigned_____
11. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
12. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
13. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
14. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.*
    State Compensation Insurance Fund (Enter address of SCIF office assigned to the institution)_____
15. Insurance Policy Number. *El número de la póliza de Seguro.* _545_____
16. Signature of employer representative. *Firma del representante del empleador.* (Form must be signed. It does not admit liability)_____
17. Title. *Título.* _____ 18. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/ *Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

SCIF 3301 (REV. 7-04) - DWC Form 1 (REV. 7-04)

STATE COMPENSATION INSURANCE FUND

(see next section)

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(see Forms or Forms Samples)